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MONTCLAIR STATE UNIVERSITY

Music Therapy In The Treatment Of Eating Disorders

by

Marah E. Bobilin

A Master's Thesis Submitted to the Faculty of

Montclair State University

In Partial Fulfillment of the Requirements

For the Degree of

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MUSIC THERAPY IN THE TREATMENT OF EATING DISORDERS

A THESIS

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Montclair State University

Montclair, NJ

2006

Abstract

This study explored the nature of music therapy services to clients with eating disorders. The purpose of this study was two-fold: firstly, to establish some of the demographic parameters of the client population and treatment context, and secondly, to explore the therapy implementation and interpersonal dynamics of the music therapy relationship with clients with eating disorders. In order to accomplish this, this study used a survey design. Thirty-six music therapists that indicated that they were currently working or had worked with clients with eating disorders completed the online survey.

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MUSIC THERAPY IN THE TREATMENT OF EATING DISORDERS

Statement of Problem/Inquiry

Although the existing body of literature supports the use of experiential therapies in eating disorder rehabilitation, there is a scarcity of research and literature on the use of music therapy with this particular client population. In addition, much of the literature concerns the use of art, dance, and drama therapy in the treatment of patients with eating disorders, despite the increasing number of music therapists working with the population (Fallon & Wonderlich, 1997; Hornyak & Baker, 1989; Loth, 2002; Parente, 1989; Zerbe, 1998). Due to the dearth of published research and literature, there exists a need for more contemporary knowledge concerning treatment protocol and the therapy implementation of music therapists working with this population. (Davis, Gfeller, & Thaut, 1999; Dokter, 1995; Fallon & Wonderlich, 1997; Hornyak & Baker 1989).

Most of the music therapy literature concerns individual work with clients with anorexia, and less is known about group processes as well as music therapy with clients with bulimia (Frederiksen, 1999; Hilliard, 2001; Justice, 1994; Loth, 2002; Nolan, 1989; Nolan, 1989; Robarts, 1994; Sloboda, 1993, 1995; Smeijsters, 1996). In addition, the majority of this music therapy literature has been written with a psychodynamic framework and describes the use of clinical improvisation, while fewer music therapy articles describe the use of alternative music therapy interventions (McFerran, 2005; Frederiksen, 1999; Robarts, 1994; Robarts, 2000; Robarts and Sloboda, 1994; Sloboda, 1993, 1994, Smeijsters, 1996; Smeijsters and van den Hurk, 1993).

In addition, the eating disordered patient population has been considered one of the most difficult to treat patient populations due to their resistance and the complex nature of the pathology. Comprehensive multidisciplinary treatment and care is often needed to achieve medical stabilization and to optimize recovery.

If music therapists are to work with this population, there exists a need for empirical and quantifiable research to support its use. Due to the lack of a comprehensive listing of clinicians working with this population as well as the lack of research, a systematic inquiry is needed. Therefore, the purpose of this study was twofold; firstly, to establish the demographic parameters of American music therapists working with eating disorders, and secondly to describe the therapy implementation, techniques, and interpersonal dynamics of music therapy work with the population.

This paper will include a review of the literature of eating disorders with a discussion of the features, etiology, and treatment of the disorder, a review of the literature on music therapy and eating disorders, and a discussion of the survey of music therapists working with clients with eating disorders. Additionally, although some individuals with eating disorders are male, the pronoun she will be used as the majority of individuals with eating disorders are female.

Research Questions

The study was guided by the following questions:

1. What are the demographic parameters of music therapists working with eating disorders in the United States?
2. What is the theoretical orientation of American music therapists working in eating disorder rehabilitation?

3. Which music therapy interventions are currently used with clients with eating disorders?
4. How is music therapy used with patients with eating disorders at various stages of treatment?
5. Which are the most effective music therapy interventions according to clinicians working with the population?
6. Does musical behavior differ between clients with a diagnosis of Anorexia Nervosa, Bulimia Nervosa, and Eating Disorder, Not Otherwise Specified?
7. What are some of the musical manifestations of pathology in patients with eating disorders?
8. What are some of the patient transferences towards the music therapist?
9. What are some of the emotional reactions of music therapists working with patients with eating disorders?
10. How are these countertransferential reactions of the music therapist implicated in the music therapy session?

REVIEW OF THE LITERATURE

This section provides an overview of the literature and concepts that guided the researcher's design, analysis, and interpretation of the study. Because the treatment of eating disorders is complex and requires interdisciplinary collaboration, the literature review is comprehensive and divided into several sections that address the complexity of the etiology and treatment of eating disorders, as well as the review of music therapy literature with clients with eating disorders.

This literature review establishes the foundation of my study because it provides the theoretical framework for the use of music therapy in the treatment of eating disorders. The literature review is divided into five main sections including a definition of the disorder as specified by the DSM-IV-TR, a review of several different theoretical explanations for the etiology of the disorder, a discussion of the complexities and "paradoxes" of the disorder and treatment, and a review of the music therapy literature concerning the treatment of clients with eating disorders.

Clinical Features of Eating Disorders

The Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association (2000) states that eating disorders are characterized by severe disturbances in eating behavior. Key features of anorexia nervosa include: the refusal to maintain a minimally normal body weight through voluntary starvation, grossly distorted body image, and fear of weight gain. Anorexia nervosa is divided into two subcategories: restricting type and binge-eating/ purging type. Other characteristics associated with anorexia include perfectionist tendencies, obsessive behavior with regard to food, the body, exercise and self-control, low self-esteem, feelings of guilt, and lack of

autonomy (Bruch, 1978, 1988; Garner, Vitousek, & Pike, 1997; Hilliard, 2001; Hornyak & Baker, 1989; Smeijsters, 1996). Obsessive behaviors include frequent weighings and “checking” of body size (DSM-IV-TR, 2000).

Key features of bulimia nervosa include: recurrent episodes of binge eating and inappropriate compensatory behavior in order to prevent weight gain, and self-evaluation unduly influenced by body shape and weight. Bulimia nervosa is further specified by purging or nonpurging type. Eating disorder, not otherwise specified is characterized by a disturbance in eating that meets some but not all of the criteria for the other two classifications. For example, despite disordered eating, the individual may not have significant weight loss and/or has not engaged in binge eating or inappropriate compensatory behaviors for more than three months. Other characteristics of eating disorder, NOS may include regular binge eating in the absence of compensatory mechanisms and/or other eating behaviors including: repeatedly chewing and spitting out, without swallowing large amounts of food (DSM-IV-TR, 2000).

Despite the classification of eating disorders into distinct categories, all individuals with eating disorders engage in behaviors that abuse the body. Additionally, many individuals with eating disorders may also possess additional Axis I as well as Axis II diagnoses and experience additional psychological difficulties including depression, anxiety, obsessiveness, affective instability, poor impulse control, low self-esteem, passivity, lack of assertiveness, dependence and need for approval as well as interpersonal difficulties (Crowther & Sherwood, 1997).

Theoretical Paradigms Of Eating Disorders

Psychoanalytic Model

Object Relations

The psychoanalytic developmental theory of Object Relations describes the infant/mother relationship in several stages of development (Goodsitt, 1997). These include: infantile autism, symbiosis, separation-individuation, and object constancy. According to this perspective, the client with an eating disorder is arrested in these early developmental stages, lacking object constancy.

Winnicott (1971) uses the phrase 'good-enough mother' to describe a caretaker who has sufficiently met the infants needs for self-regulation in the symbiotic stage of development. If the primary caretaker has met the infant's needs, the child may internalize these behaviors and begin to successfully separate from the mother. If the primary caretaker fails to adequately meet the infant's needs, the individual will not be able to internalize these self-regulating functions and will not be able to provide her own sense of security (Nolan, 1989). Additionally, if the caregiver is unable to 'contain' the infant's raw feelings and returns them back to the infant in their 'raw' form, the infant may experience this as an attack. Conversely, the infant may be the 'container' of the parent's anxieties and experience these projections as harmful 'foreign bodies' (Loth, 1988, p. 92). Psychoanalytic theorists believe that the internal conflict arises in this developmental stage, in which the child never experienced a sense of self and acceptance in the caregiver relation, but was rather a container of parental projections (Loth, 1988).

It is thought that patients with eating disorders use the language of the body to express trauma that has been encoded in this early preverbal stage (Fallon & Wonderlich,

1997; Zerbe, 1997). Because these emotional encodings of experience may have occurred at a preverbal stage of development, the eating disorder represents a defense towards these emotionally traumatic experiences (Rogers, 1995). As the child develops, he or she develops language for these somatic experiences, and begins to associate “feeling fat,” with these types of emotional attacks and uses the eating disordered behavior to cope.

Winnicott (1971) also describes the concept of a ‘transitional object’ which is the object that the child uses during weaning to provide self-soothing and comfort when the primary caretaker is not available. This ‘transitional object’ is the object that the child totally controls and never changes, unless by the child, and can survive both instinctual love and hate. Object-relations theorists believe that the eating disordered patient uses the disorder as a transitional object. Therefore the use of the eating disorder as ‘transitional object’ also illustrates the anorexic’s attempt to control her body and food in order to provide herself with a sense of security and control (Goodsitt, 1997).

Ego-psychology

The ego-psychology model is helpful in understanding the origins of the personality traits including lack of autonomy and self-esteem. This model evolves from Winnicott’s example of a ‘false self’ that may result from insufficient caregiver/infant relations as well as “enmeshed” family systems.

The ego-psychology model states that anorexia is a manifestation of a weak ego that failed to develop independently during childhood. Ego-psychologists believe that an independent ego failed to develop during childhood because the child overidentified with the mother and did not attain separation and individuation. Bruch (1988) states that

anorexics in their symbiosis with the parent, usually the mother, fail to develop the ability to identify their own needs and perceptions including control of bodily sensations and emotional states.

Because the child's sense of self is so intertwined with that of the caregiver, she may only express herself in terms of what the caretaker may approve, and thus fails to develop autonomy. As a consequence of this enmeshment, she may experience considerable difficulties in separating from the mother. Goodsitt writes that the eating-disordered individual "negates her selfhood. Instead, she directs her attention to pleasing, accommodating, and being sensitive to others. The guiding rule is to serve others by meeting their needs. She strives to become a selfobject (i.e., a function for others) and not a self" (p.212). He describes the 'selfguilt' that individuals with eating disorders then experience for having feelings and needs that are different from that of the caregivers or wanting to have a separate identity. He writes "An act of occupying psychological space is experienced as an immoral, hostile, and destructive act that deprives others of their psychological space" (p. 213). This concept of self-guilt can explain the self-starvation or the bingeing experience in which she reverses her obligation to care for others and is intensely devoted to her self-experience (Goodsitt, 1997).

The child strives above all to please the parent and the cycle of perfectionism becomes well established in childhood and continues until adolescence where the disorder usually becomes manifest. In childhood, such perfectionist behavior, although superficial, yields praise from both parents and teachers and this façade becomes perpetuated until the crisis of adolescence. During this time the individual is confronted with changing social roles and expectations for which these individuals are ill-prepared to

cope. By this time the goals of others have become internalized and the individual attempts to focus this attention on the body. The eating disorder then becomes the identity (Smeijsters, 1996).

Cognitive-behavioral Model

The central tenet of the cognitive-behavioral model regarding the development of the disorder is that individuals with eating disorders overvalue the importance of body shape and weight and consequently engage in abnormal eating and elimination behaviors.

The cognitive-behavioral theory developed by Fairburn, Shafran, and Cooper (1998) states that the individual becomes anorectic because of her perceived overall ineffectiveness in other areas of functioning and turns to the eating disorder as the only successful experience. The individual with anorexia also has a need for control and views the eating disorder as the aspect in life that can be controlled. The eating disorder thus becomes very important to the individual, as one client with anorexia exclaimed, "If I let go of my eating disorder, what will I have left?" (Sloboda, 1993, p.105). An example of distorted thinking resulting from low self-esteem includes the following, "I was not giving anything to the world, so I did not have the right to eat" (Bruch, 1988, p. 175).

The cognitive perspective states that the eating disorder becomes self-perpetuating because of this type of distorted thinking (Fairburn, et al., 1998). This cycle perpetuates also because of the frequent body monitoring, in which a presumed weight gain becomes intolerable and aversive (Garner, Vitousek, & Pike, 1997). For the patient with anorexia, her self-esteem may be gained by "practicing the self-denial of dieting" (Sloboda & Robarts, 1994, p. 8). Clinicians also believe that for many patients with anorexia, the ability to control hunger provides the patient with a feeling of control over

the emotions, discipline, self-sufficiency, control, and success, while feeling “fat” is symbolic of feeling a loss of control, depression, neediness, and greed (Robarts & Sloboda, 1994). This may be why the patient with anorexia may present as a overachieving “hyperactive” presenting a persona that is “jolly, active, and friendly” (Robarts & Sloboda, 1994, p. 10).

Complex Issues with Patients with Eating Disorders

Paradoxes of the Disorder

It is important to mention the paradoxes of the illness in order to understand the complexity of the disorder. Smeijsters (1996) describes several paradoxes of anorexia. The first paradox concerns the simultaneous longing for and the avoidance of intimate relationships. He writes that this is because each “merging inevitably included separation” (p. 10). Secondly, for the anorexic, self-starvation successfully allows her to avoid negative feelings, but “feeling hungry” as Smeijsters writes is “a means to feel” (p. 11). Also, although the eating disorder is heavily clung to as the “successful” aspect of the patient’s life, the individual may feel a sense of failure from their “heightened sense of fullness,” hunger pangs and binge/purge cycle. Finally, Smeijsters (1996) mentions another paradox in that initially the woman feels a sense of increased self-esteem as the result of weight loss, but this self-esteem soon diminishes because the woman feels that she can never be thin enough.

Rogers (1995) describes music therapy work with a client that had a history of abuse predating the eating disorder. She suggests a paradoxical function of the eating disorder, “it is only through the destruction of her body, which keeps the abuse survivor tied to a dangerous world, that she can survive (p. 269).”

Therapy with clients with eating disorders is a complicated task. Vandereycken and Beumont (1998) write that treatment with this population “remains controversial, always difficult, usually protracted, and often unsuccessful” (p. vii.). The eating-disordered population has been considered one of the most difficult populations to treat because they are initially so resistant to treatment (Fairburn, et al., 1998; Goodsitt, 1997; Zerbe, 1998). Such resistance to treatment is illustrated by anorexics’ acute denial of their illness (Bruch, 1988; Zerbe, 1998). Bruch (1988) warns that many therapists who work with anorexics fail to see past this denial and consider the clients to be deceitful or dishonest because they do not consider themselves suffering from an illness nor profess to view themselves as emaciated. Such suspicions are indeed likely to be detrimental to the client’s treatment as it may reinforce a vicious cycle Bruch defines as “systematic training in dishonesty” (p. 87). She explains that many therapists fail to acknowledge that these patients entire existence has been founded on false experiences wherein others acknowledge only “good” behavior and other feelings including misery and depression are ignored.

Goodsitt (1997) writes that this resistance may be better understood if the therapist understands the role of the eating disorder in the client’s life and that the eating disorder protects the client from not feeling difficult or unpleasant emotions and represents security and identity. Because emotions are communicated and understood as bodily impulses, the individual with an eating disorder attempts to control difficult emotions by controlling physical impulses and bodily needs via maladaptive eating behaviors. In this manner the individual becomes disengaged from their emotional state and sense of self (Dokter, 1995). Bruch (1988) writes that the complex task of therapy

involves guiding the client in her search for identity through the discovery of natural impulses and repressed emotions.

Transferential Dynamics

As the therapist helps the patient to uncover repressed emotions, he/she may also begin to experience a number of physical and emotional reactions garnered by the therapeutic process. Zerbe (1997) writes that when working with eating disordered patients "having strong feelings is the rule rather than the exception" and that many clinicians experience "self-vilifying internal criticism and personal vulnerability" (p. 32). These emotional reactions or countertransference reflect that an important transferential dynamic has taken place. Because the client's transferences towards the therapist may reflect early developmental issues, a variety of raw emotions may emerge.

Individuals with severe eating disorders may develop intensely negative transferences towards the therapist. These transferences may reflect a fear of being controlled or dominated by the primary caretaker. Zerbe writes that one severely ill anorexic shouted to her from the bedside, "I don't want you taking over my body!" (p. 36). Because the goal of treatment is to help the client to express and tolerate difficult emotions as well as to develop autonomy, allowing and tolerating this negative transference builds the therapeutic relationship. Although "containing and surviving" these negative transferences may be difficult, it may be exceedingly helpful for the client who has been previously unable to express her emotions within her family of origin and/or other relationships. Because patients also have a need for the therapist's compassion and empathy, these emotions may alternate with a desire to be emotionally "held and soothed" despite the therapist's neutrality and inability to fulfill these infantile needs.

Zerbe (1998) writes that another complication of this transference dynamic is that the therapist may experience maternal transference toward the anorexic and want to physically hold the patient. Zerbe (1998) advises that this maternal transference of the client to the therapist should be "contained" rather than acted upon by the therapist in aggressive retaliation or physically holding the client. Zerbe continues that, "Such desires to hold or nurture the client can be better dealt with in the experiential therapies." She continues that the experiential therapies represent a forum wherein the client can "begin to share her pain rather than acting on it...while cognitively developing a secondary process language for the feelings" (p. 48).

Music Therapy Clinical Work

The eating-disordered individual is driven to constant activity in order to avoid difficult emotions (Goodsitt, 1997). While verbal therapies use language and thinking in anticipation of action and provides an indirect intervention, experiential therapies such as music therapy, are action and process oriented (Bruscia, 1998). The use of music as emotional communication may be a viable use in treatment for individuals with eating disorders who customarily use the body as a symbol of emotional distress and/or have the tendency to intellectualize emotions. Through the interactive process of music, the client can work through arrested stages of development, explore feelings and gain a new awareness of herself, and develop insight into the cognitive distortions through the use of symbol and metaphor.

Because a crucial component of treatment is to assist clients in identifying and tolerating difficult emotions, music can be used to help the patient express emotions rather than resorting to symptomatic behavior as a defense. In addition, because

traumatic experiences due to early developmental issues or abuse may be encoded on a pre-verbal or non-verbal level, patients may not have a semantic code for identifying and labeling these emotions (Fallon & Wonderlich, 1997, Parente, 1989; Rogers, 1995). The use of music therapy may offer a means for the patient with past trauma to express these procedural memories (Rogers, 1995).

Individual Music Therapy

Most of the music therapy literature on eating disorders is discussed from a psychoanalytic framework and concerns the use of improvisation to work through arrested stages of early development. Robarts (1995) describes the process of working through these developmental stages with an anorexic 13-year-old. She writes that in the beginning of the improvisational work, the client's musical expression "seemed to depend on mine, following every pattern and nuance." As the work progressed to the stage of separation-individuation, the client began to "initiate brief moments of more focused and assertive dialogue," and finally, "more actively and dynamically, initially through identifying with my music, then spontaneously initiating her own ideas" (p. 239-240).

Rogers (1995) discusses how musical improvisation was used to provide a medium in which her client's experiential memory of sexual abuse could be expressed and contained. She writes:

"The therapist attempted to facilitate Jill's musical expression and provide a space and time within which the feelings attached to transference, countertransference, and the new symbols created through the therapeutic relationship could become meaningful. The musical expression itself was regarded as meaningful as Jill projected her chaotic feelings into the therapeutic space. The therapists acted as a container for what Jill experienced as uncontainable feelings (projective identification). It was vitally important to Jill that the therapist was experienced as being able to contain these aggressive emotions and was not destroyed as she feared. The therapist was thus experienced by Jill as the good enough

mother, able to contain both musically and subsequently verbally both her confused, angry, and chaotic expression. That the therapist did not reject her helped Jill to acknowledge feelings of self-revulsion, poor self-image, and self of alienation. The duality of the resulting musical improvisation offered her the experience of being both heard and listened to, with the improvisation functioning as a transitional object” (p274-275).

Sloboda (1995) describes how the technique of thematic improvisation can be used to enable clients to make connections between aspects of their playing and their emotions, as well as the function of the eating disorder. Her work also includes the use of musical role play, an improvisational technique in which patients are asked to play the music of specific character or persons in their life. She describes how a discussion of the “character’s” music may enable the client to develop insights regarding the roles of these individuals and emotional content of these relationships. She writes, “the immediacy of the experience of free improvisation helped them become more conscious of their emotional state” (p. 252).

Fredericksen’s (1999) work focuses on the use of clinical improvisation to facilitate emotional expression and the development of autonomy in a client with anorexia. She uses a variety of rhythmic “grounding” techniques to provide an environment for the client to explore and separate musically (p. 222).

Smeisters and Hurk (1993) use a qualitative design to explore improvisational work with a client with anorexia. Their work focuses on the representation of manifestations of anorexia in the musical material and suggests that identifying and expressing emotions is the primary focus of music therapy for patients with this disorder. Throughout the music therapy literature on eating disorders, musical manifestations of pathology remains a theme and will be discussed in the sections following group work.

Group Music Therapy

A variety of group music therapy strategies have been described in the literature including musical improvisation, music performance, and music and imagery. McFerran (2005) emphasizes the ability of the group music therapy context to provide a “theatre for personal and cultural change that does not exist in individual work,” and to facilitate developmentally appropriate dynamics including sibling rivalry, attachment and independence.

Nolan (1989) describes how musical improvisation can function as a transitional object to disrupt the binge-purge cycle. He described how when patients began to experience overwhelming affect during the group improvisation; many patients found that instead of feeling a loss of control, they reported feeling safety by “merging with the beat” (p. 111).

Parente (1989) discusses the use of a performance group to help clients with eating disorders target a number of goals including: working through fears via rehearsal and performance of songs, substituting alternative behaviors for the disorders, providing an opportunity for positive social experiences and the development of interpersonal skills, and finally, by providing an opportunity to improve self confidence by successfully accepting, learning, and performing a role.

Hilliard (2001) describes the use of cognitive-behavioral music therapy in an inpatient setting, and Justice (1994) describes several musical interventions with an inpatient group used at various levels of the rehabilitative process. The specific use of music therapy interventions in the group context will be discussed in the following sections.

Music Therapy in the Supportive Stage

Goodsitt (1997) writes that the main issue of treatment in this stage concerns the client's reluctance to enter therapy. Because the inpatient is obliged to discontinue her use of eating disordered behaviors in the first stage of therapy, many feelings may begin to surface in the form of anxiety (Justice, 1994).

Both Justice (1994) and Hilliard (2001) describe the use of directed imagery techniques for relaxation and as a means to provide the patient with alternative methods of dealing with stress. Justice (1994) and Parente (1989) suggest that the use of these music-reinforced relaxation techniques could be used in a music therapy group after meal time to help patients direct attention away from obsessive thoughts.

Music therapy activities have also been used in the supportive stage to establish meaningful contact and rapport with the client and to prepare the patient for the transition to a the re-educative level of therapy (Nolan, 1989). Justice (1994) Parente (1989) and Nolan (1989) describe how several musical activities including structured improvisation, handbell playing, and group singing may provide the patients with a safe and successful musical experience and catalyze the group to take more risks.

Nolan (1989) describes how the use of improvisation in this initial stage provides an opportunity for patients to explore the expressive range of instruments as well an opportunity for group members to be spontaneous with each other. Nolan (1989) used a variety of structured improvisation accompaniment techniques including prepared scales on xylophones and harmonic progressions to facilitate the improvisation. He remarks that the musical responses and interactions of patients can serve as a means of assessment and can be worked with in various ways including, "imitating by echo, harmonizing the

motifs, adding rhythmic subdivision, and creating antecedent/consequent dialogs with rhythmic or melodic motifs” (p. 50).

Music Therapy in the Re-educative stage

The next stage in the treatment process is the re-educative, insight-oriented level. In this stage, individuals may begin to identify the feelings and cognitive distortions underlying the eating disorder. Music therapists working with clients with eating disorders have described how clients have associated aspects of their playing with aspects of both their internal world and their interpersonal relationships (Nolan, 1989; Roberts & Sloboda, 1994).

Hilliard (2001) describes the use of lyric discussion in a cognitive-behavioral music therapy program for inpatients with eating disorders. In this intervention, he asked the clients how they could relate to the song “Running on Empty.” He found that, “For many patients, the song served first to verbalize and give a voice to the feelings they had of giving too much of themselves away to others: family members, pressures of work, or stress at school. It also served as validation for their feelings” (p. 111). Hilliard then asked the group if they knew of any ways that their eating disorder served to address the uncomfortable feelings associated with feeling out of control, tired, and perfectionistic. This technique gave the patients insight into their psychopathology, that the underlying feeling of inadequacy purported the use of their disorder. The group then dialogued to find healthier means of coping to substitute for the eating disorder.

Loth (2000) describes the use of thematic improvisation in a group of mixed eating disordered patients, in which the group members were instructed to “play what they came in with.” She describes how a “typical” group dynamic wherein patients

would move around between various instruments, fail to musically connect with each other, and eventually fade out prior to the end of improvisation, progressed to the development of group cohesion. She remarks that as the sound died down during this improvisation, the group “fell into a slow beat that was shared by all” (p. 98). She describes how patients were not only able to obtain relief through the playing, but to move from that to becoming aware of each other through the music.

Group MT improvisation has been used to help clients build interpersonal skills and develop new ways of relating. Nolan (1984) discusses the use of a tape recording he used to challenge the cognitive distortions of members in a group. He describes how before listening to the playback, clients’ statements often reflected low self-esteem and negative connotations regarding their individual sound in the group. One client said, “It sounded fine until I started playing the tambourine too loud” (p. 180). Following the objective feedback of the tape, many patients expressed great surprise over the difference between their perception of their function in the group and their actual effect. Verbal group processing of the improvisation may be another helpful way that one can challenge cognitive distortions.

Group singing has been used to help patient begin to accept themselves and to be less concerned with perfectionism (Justice, 1994; Parente, 1989). Hilliard (2001) and Parente (1989) describe how positive social experiences may be experienced as one sings with the group and shares her voice with others in a group.

Music Therapy in the Re-constructive stage

The re-constructive stage in treatment is one in which the client is well past the crisis stage of treatment, has insights into the core issues underlying the disorder and is

working toward re-constructing the personality structure and resolving past conflicts which may hamper personality development (Goodsitt, 1997). Music therapy has also been used in this re-constructive stage to help clients gain greater insight into past conflicts and to resolve these conflicts.

Nolan (1989) describes how a client's playing of an instrument may symbolize the underlying issues. He discusses a patient who only played in the top register of a xylophone. She was asked why she only played in the high register, she remarked that she wasn't comfortable with the "low guys." Nolan (1989) describes how she was encouraged to explore the lower register to discover what series of tones made sense to her. As she explored the instrument, she began to experience intense affect during the improvisation and was encouraged to stay with these feelings in the music. As the group musically supported her expression, she was able to fully experience the difficult emotion, and this musical interaction provided the emotional integration that was needed.

Justice (1994) describes the use of music and imagery at this stage in eating disorder rehabilitation. In this method, the individual is guided by the therapist to focus on a symbol during music listening; afterwards, she may share this symbol with the group. She describes how the patient may make a connection between herself and the symbol and develop a greater awareness into her feelings and herself.

Although the current body of literature supports the use of music therapy in the treatment of clients with eating disorders, the resistance of clients with eating disorders to interactive musical experiences such as improvisation has also been widely documented. Throughout the music therapy literature on eating disorders, several manifestations of

pathology have also been observed in the music of clients with eating disorders and these will be discussed in the following section.

Musical Manifestations of Pathology

Several manifestations of psychopathology have been observed in the musical behavior of clients with eating disorders, and these manifestations seem to parallel the characteristic symptoms of the eating disorder. Robarts and Sloboda (1994) describe some of the symptoms of individuals with anorexia. These include: playing in complete synchrony with the therapist, or conversely, difficulty in interacting musically with the therapist, difficulty in beginning and terminating a musical piece, lack of vitality and creativity in playing, and the incapacity to play forcefully (Smeijsters 1996; Robarts & Sloboda, 1994; Robarts 1995). Also evident in the playing of anorexics are lack of or too rigid a musical structure, lack of musical rests and phrasing, flexibility in speed and dynamics, and a preference for high pitched tones over low tones (Robarts & Sloboda, 1994).

Playing in complete synchrony with the therapist could indicate a need of the client to be nourished by another. Smeijsters (1996) states that the client's inability to begin or terminate the musical piece could indicate a fear of musical contact and consequent separation. The hesitance to begin the improvisation may also exemplify the client's fear of making mistakes, thus illustrating characteristic perfectionist tendencies and low self-esteem. Very rigid playing may also indicate a fear of failure and dependence (Bruscia, 1987; Frederiksen, 1999; Smeijsters, 1996). Aspects of music making that are thought to indicate a desire to be weightless, include the absence of dynamics and articulation, as well as the mechanical nature of an individual's playing

(Frederiksen, 1999). When action oriented improvisation is combined with verbal processing, clients may start to become aware of this aspect of their playing. Frederiksen (1999) in a verbal discussion with her client commented on their improvisation to which the client responded, "I do not have much energy to listen to others at the moment" (p. 227).

Sloboda (1995) describes how the rigid control of patients with eating disorders is illustrated in their improvisations including "tight rhythmic patterns, a difficulty in slowing down, a lack of phrasing, flexibility, or variation in rhythm and volume" (p. 253). She describes how one man with bulimia would play relentlessly until "physically exhausted" and a woman would play similarly "until her arms ached" (p. 253). These patients are quoted as saying, "I felt I ought to keep going," and "I didn't want to give up too soon" (p. 253).

Loth (2002) described how music might also be used as a defense. While some groups of patients with eating disorders may "make a huge amount of noise, which rather than being an expression of feelings that allows for thought and reflection, is an expelling of feelings which are undigested and allow no interaction with other group members or the therapist" (p. 99).

Loth (2000) describes how the music of a group of anorexic and bulimic patients was remarkably disconnected from each other. She writes, "The anorexic's ability to freeze out everyone else and not notice what is going on around her is carried into the music. Bulimics often cut right across everyone with their loud surges and uncontrolled outburst of playing" (p. 101). She also describes how this group of patients with mixed diagnoses may facilitate more active musical involvement. She writes, "The anorexics can be

envious of the sounds the bulimics are able to make and they have more freedom to play themselves as they can 'hide' beneath the levels of the 'bulimic' music, as well as compete with them (p. 95).

Analysis of the Literature Review

The dynamic aspects of music lend itself to working in a variety of ways and on many levels in the treatment of eating disorders. However, the majority of the literature has included case vignettes, with the exception of one qualitative case study, and none have compared and evaluated the current practice of music therapists that currently work with patients with eating disorders. In addition, much of the music therapy literature has focused on the individual treatment of anorexics with only four have described group work with this population.

The purpose of the proposed survey is to describe the current practice of music therapy with clients with eating disorders in order to present a contemporary understanding of the clinical work. This study seeks to explore the process of music therapy with clients with eating disorders in order to answer the following questions: How are various music therapy interventions implemented? How does the music therapist determine the structure of the session in work with both individuals and with groups? The final focus of this descriptive study is to formulate a demographic overview of the music therapy work with clients with eating disorders in order to stimulate new areas of interest and research.

RESEARCH METHOD

Study Design

The researcher used a questionnaire to obtain research data.

Research Instrument

The researcher designed a three-part questionnaire consisting of 25 closed-ended and open-ended questions based on the conceptual theory presented in the review of the literature. The first part of the survey consisted of multiple-choice questions that were used to obtain demographic and background information, followed by a series of open-ended questions that were used to obtain information regarding theoretical orientation, treatment philosophy, and therapy implementation in the second part, and interpersonal dynamics in the third part.

Sampling Frame

The initial sampling frame included 46 members of the American Music Therapy Association's annual sourcebook listed as working with the eating disordered population. Due to the low response rate, 8%, with only 3 surveys returned via US post, the sampling frame was expanded to include 169 AMTA members listed as working with both the eating disorder and the mental health population. It was hoped that many of these professionals work with clients with eating disorders, but may not have indicated this as their primary population on the AMTA membership form.

Data Collection

Prior to data collection on both occasions, the researcher sought and obtained approval from Montclair State University's Institutional Review Board. The researcher then sent 169 emails to participants with a consent form and a URL address directing

participants to an online version of the survey. Because participants had been previously contacted via email they were asked to refrain from completing the online survey if they had already mailed back a survey.

The total response rate was 38%, with a total number of participants, N=64, representing the total response rate from the initial email contact in Nov. 29, 2005 until March 29, 2006. Although low, this response rate may be typical for an online survey. However, although the total of 64 participants initially responded to the survey, only 36 (51%) of participants met the criteria for completing the survey, stating that they currently or have worked with patients with eating disorders in the past.

Using the online survey software program, Survey Monkey allowed the researcher to control for a number of factors. In order to preserve anonymity, the researcher opted not to track the identities of the respondents. Participants were also able to skip questions but were disallowed to make more than one entry per question. If the respondent attempted to access the survey from the URL address after they had finished, the participant was only able to answer questions that were previously unanswered.

Data Analysis

Data was collected using both multiple choice and open-ended questions in the survey in both the paper and online survey formats. The raw data from mutually exclusive questions was initially held by the survey software program, SurveyMonkey, and later analyzed using descriptive statistics by the researcher.

The researcher used thematic content analyses and the constant comparative method to analyze data from answers to open-ended questions. Following coding, the

output of the content analysis was also analyzed using descriptive statistics and presented in a series of bar graphs.

RESEARCH RESULTS

Demographic Information

Participants included 36 music therapists currently working with patients with eating disorders or stating they had done so in the past. Only one participant stated that although they did not work with the population, they were interested in doing so. The remaining 42%, (n=27) of the initial 64 respondents answered, “no, they did not work with clients with eating disorders,” and these participants were directed to the final page of the survey.

Of the 36 participants, only four, or 11% of participants stated that they worked primarily with patients with eating disorders. The remaining participants stated that they replied that they worked predominantly with other populations including other mental health disorders, Autistic and other developmental disabilities, and the geriatric population.

Context of Treatment

The most common context of care of patients with eating disorders was the inpatient treatment facility, with a frequency rate of (70%; n=28), followed by the hospital setting, with a rate of (39%; n=14), and private practice (30%, n=12).

The remaining filled out “other” and mentioned specific facilities including: two participants treating patients with eating disorders in the school setting, two treating patients in a day treatment facility, one serving patients in a juvenile residential facility, and one treating patients with eating disorders within a state psychiatric hospital.

Figure 1. summarizes the results.

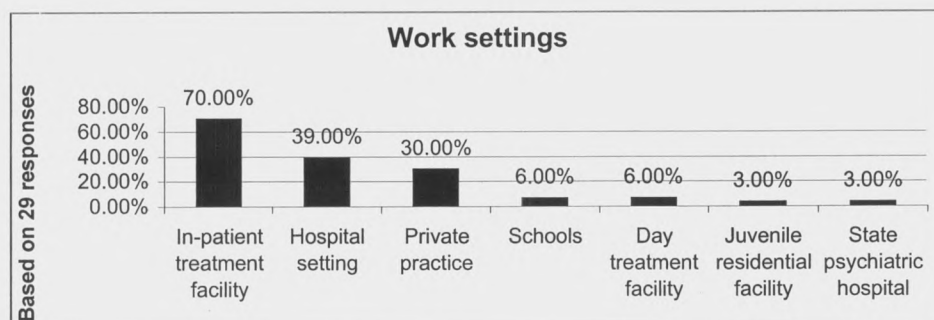
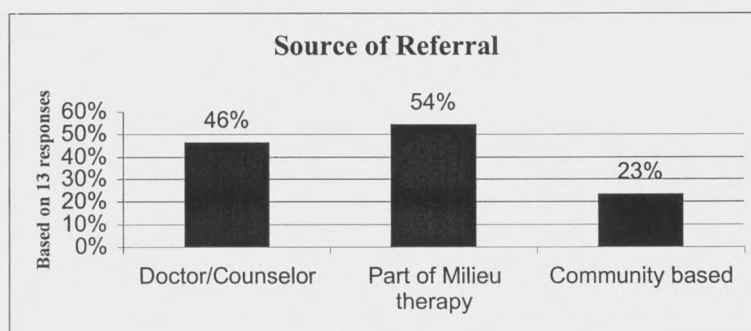


Figure 1. Work settings of music therapists working in eating disorder rehabilitation. The bars indicate the percentage of participants who provided music therapy to patients with eating disorders in the particular work setting.

Method of Referral

Because the majority of patients with eating disorders receive music therapy as part of the milieu therapy in the inpatient setting, it exists as the primary source of referrals. Patients treated in the hospital setting are referred to music therapy by their primary therapist or another medical health professional, while community based referrals included referrals from friends and family, as well as self-referrals. Figure 2 illustrates the most frequent referral source for music therapists working with eating disorders.



Patient Demographics

Music therapists were asked to specify their clientele by diagnosis. Figures 3 and 4 summarize the results.

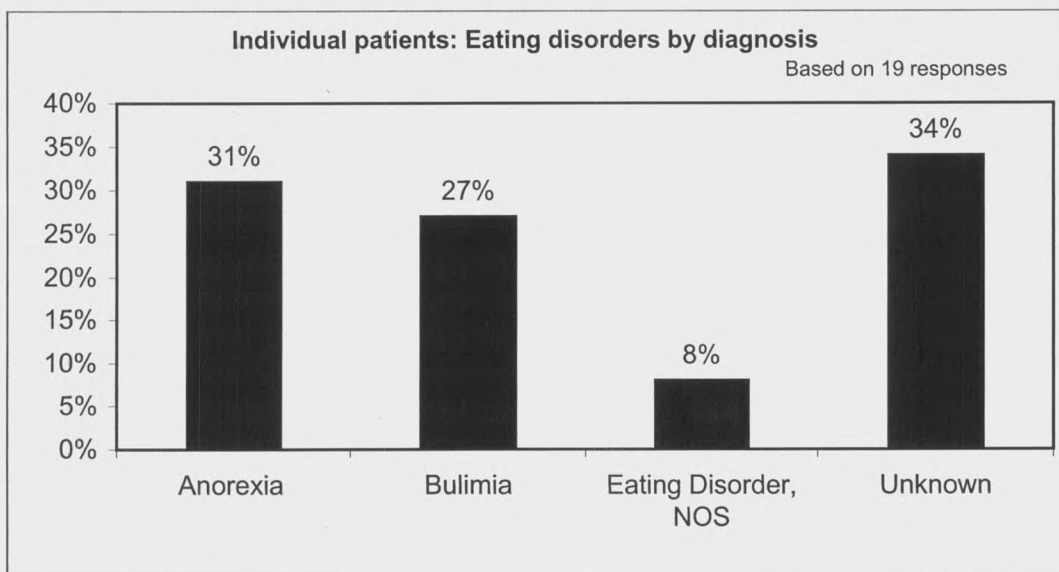


Figure 3. Individual patients: Percentages of eating disorders by diagnosis

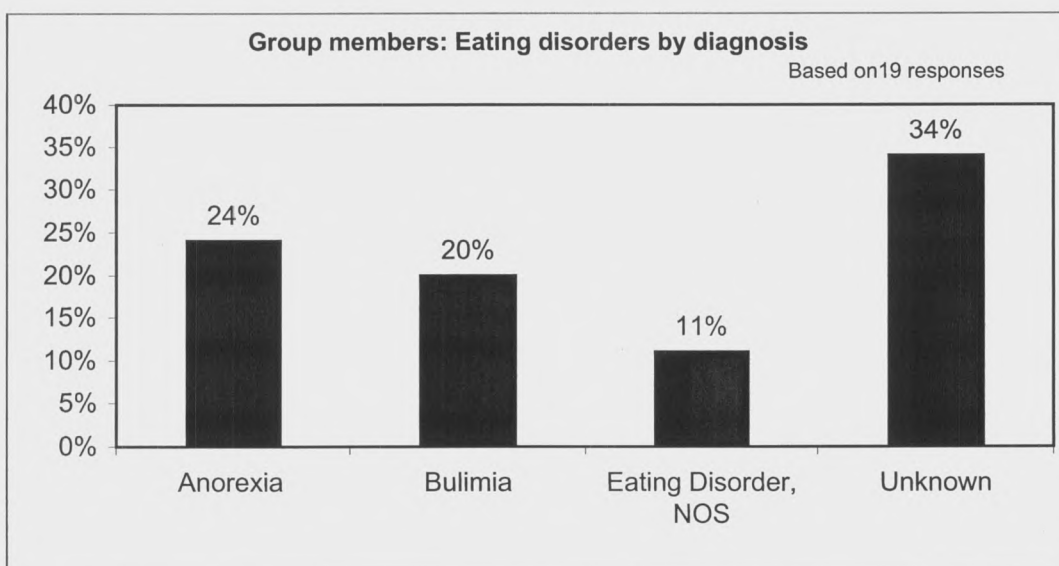


Figure 4. Group members: Percentage of eating disorders by diagnosis in music therapy groups.

Theoretical Orientation and Approach

Participants were asked to provide their theoretical orientation. Twenty-four participants provided information regarding their theoretical orientation in a short-answer format and frequently listed more than one paradigm. Figure 5 indicates the percentage of participants that listed the particular theoretical orientation.

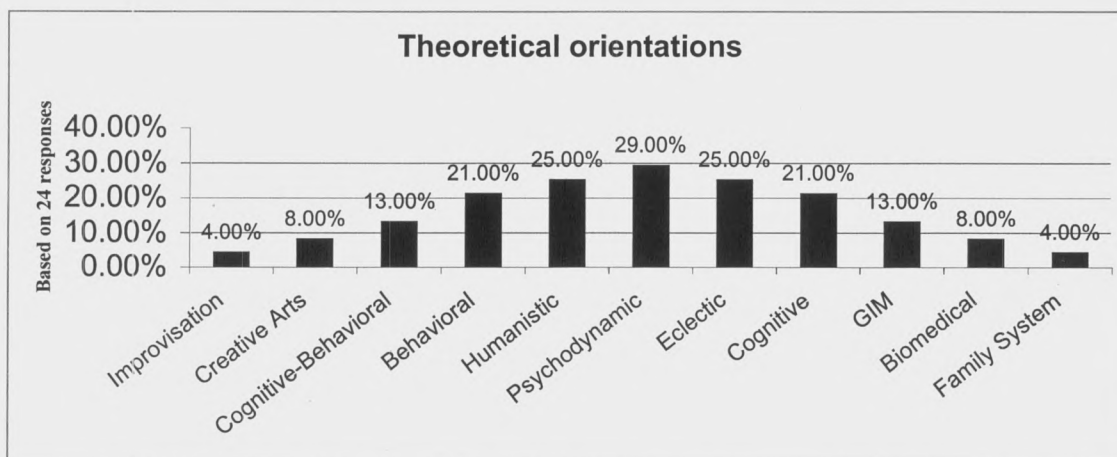


Figure 5. Theoretical orientations of music therapists working in eating disorder rehabilitation.

Although the psychodynamic paradigm was the most frequently utilized paradigm (29%), eight or 34% of the sample identified with the Cognitive/Cognitive Behavioral perspectives, with five specifically citing Cognitive and three citing Cognitive-Behavioral, and six participants described their orientation as eclectic.

Treatment Philosophy

Participants answered questions concerning their treatment philosophy as it related to working with persons with eating disorders. This question was divided into three sections including: their belief concerning the etiology of the disorder, their belief concerning music therapy with the population, and their ongoing assessment process.

Etiology of Eating Disorders

Participants frequently reported that the etiology of the disorder resulted from multiple sources, with 11 (61%) participants stating that the etiology of the disorder results from an interaction of 'biopsychosocial' causes. Figure 6. summarizes the results.

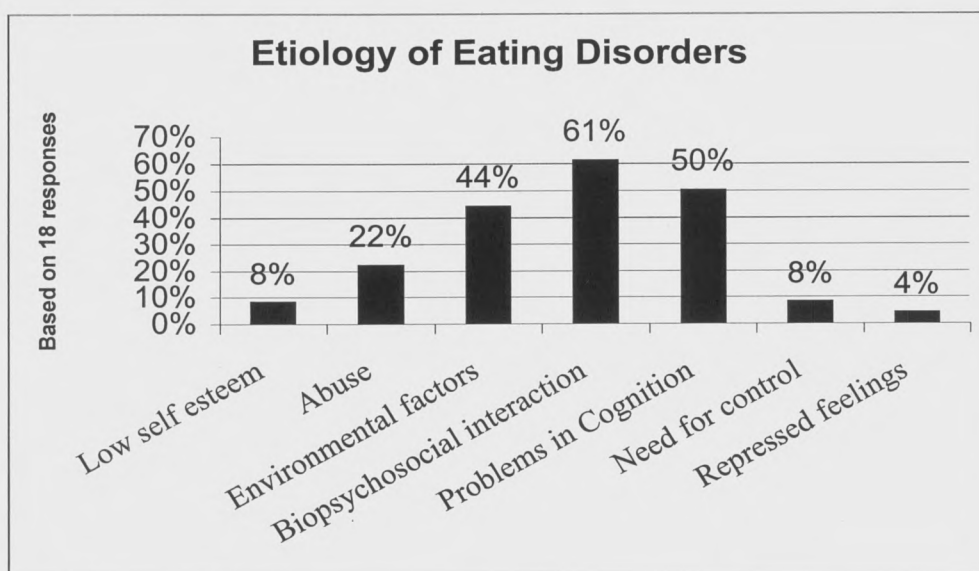


Figure 6. Etiology of eating disorders.

Music Therapy Goals

Participants were asked to describe how they believed music therapy should be used with this population. The two most common goals included the use of music therapy to provide an outlet for emotional expression and to increase areas of cognitive functioning.

Nine participants (47%) responded that music therapy should be used to provide a medium for emotional expression. Participants stated that music therapy should be used "As an expressive modality," "As a way to provide a voice for feelings," and "To help

clients express their emotions,” as well as “to encourage expression and work through trauma,” and “as a catalyst for talking about underlying issues.”

Nine participants (47%) also responded that music therapy should be used to increase cognition regarding the disorder. Specifically, these cognitive goals related to three areas: developing an awareness of the eating disorder, insight into the underlying issues and the origin of their problems, and to identify distorted thought processes. Three participants discussed the importance of helping patients to develop an awareness of the eating disorder. These responses included, to “help patients recognize and identify the disorder,” to work on “reality testing,” and “the development of insight into the destruction of self/body.”

Other responses pertained to developing insight into maladaptive thought processes including, “to adjust negative thinking,” “to discover differences between what one can and can’t control, and “to have a less distorted sense of self-worth.” Several participants discussed the importance of understanding underlying issues and “the origin of their problems.”

Eight participants (42%) also described a variety of uses that were collapsed into “skill building” goals. Out of these responses, the most commonly expressed uses included, to build self-esteem and self-image mentioned by 5 or 26% of participants, to increase coping skills mentioned by 3 or 16%, and stress relief/anti-anxiety mentioned by three or 16% of participants. In this category, one participant (5%) mentioned “self-care,” and another participant (5%) believed music therapy should be used to introduce positive leisure activities.

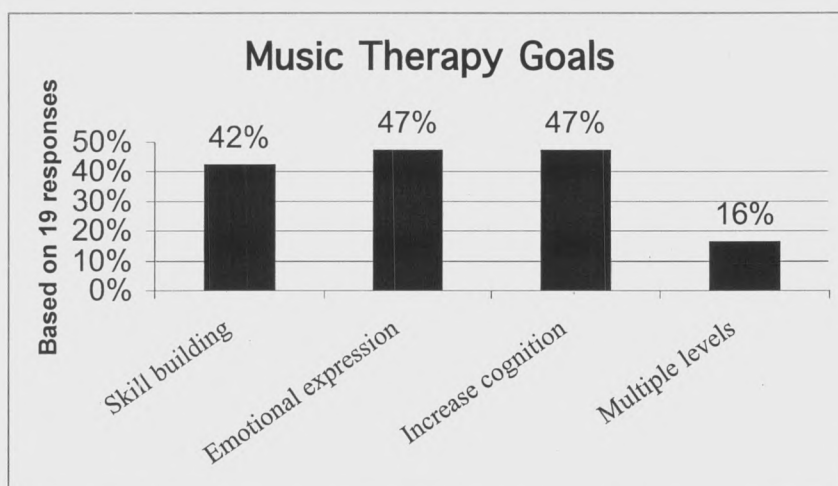


Figure 7. Goals of music therapy with clients with eating disorders.

Means of Assessment

The final part of this question concerned the assessment process, and asked participants to describe how they measure progress and change in the treatment of clients with eating disorders. The majority of participants indicated that they derived their assessment of patients using multiple modalities. Figure 8. summarizes the results.

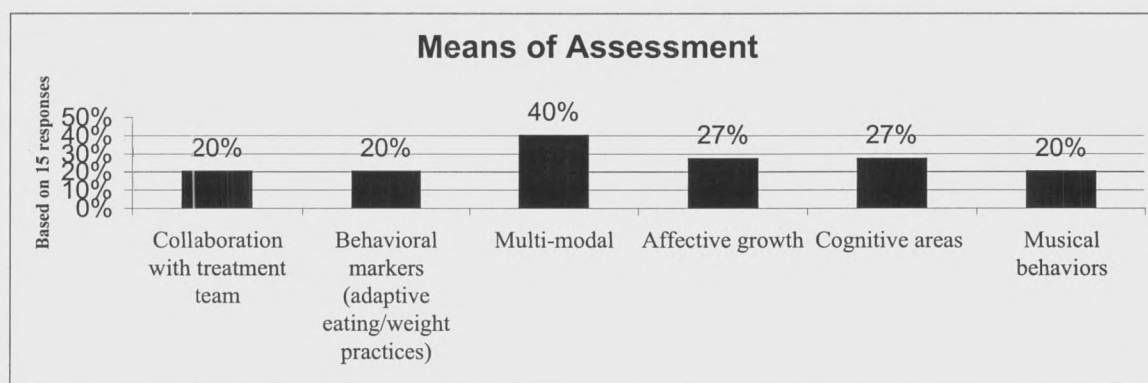


Figure 8. Means of assessment of clients with eating disorders.

The second most common means of assessment was the measurement of the degree to which the patient developed an increase in self-awareness/insight as well as

emotional expression. Eight out of 15 participants, or 53% of those music therapists surveyed, shared that they assessed patients in this manner.

Participants also mentioned that their assessment measure was derived from treatment team meetings (3 out of 16, 19%), musically (3 out of 16, or 19%), and/or from behavior markers, defined as adaptive eating behaviors and/or weight (3 out of 16, or 19%).

Interestingly, musical assessment was defined by one participant as, “musical skills of self organization,” as evidenced by the client’s “ability to play with others and steady beat.” Another participant described their musical assessment by evaluating “changes in the musical improvisation,” and another participant’s musical evaluation was based on the client’s participation in the activity.

Therapy Implementation

Levels of therapy

Participants were asked to specify the level of therapy in which music therapy was rendered to clients with eating disorders. In order to accomplish this, participants were asked to check all that applied between Supportive, Reeducative, and Reconstructive levels. The primary researcher had provided working definitions for the levels, specified as: ‘Supportive level: interventions that seek to support and maintain level of functioning rather than to provoke change, Re-educative level: interventions that seek to help the client identify cognitive distortions (i.e. helping the client to become aware of the ways in which the eating disorder is controlling him/her), and the Reconstructive level: interventions that assist the patient in integrating aspects of the self; a process approach to therapy in which the therapist and client explore maladaptive relational patterns and

emotional reactions in order to help the patient resolve these issues within the therapeutic alliance. Figure 9. summarizes the results.

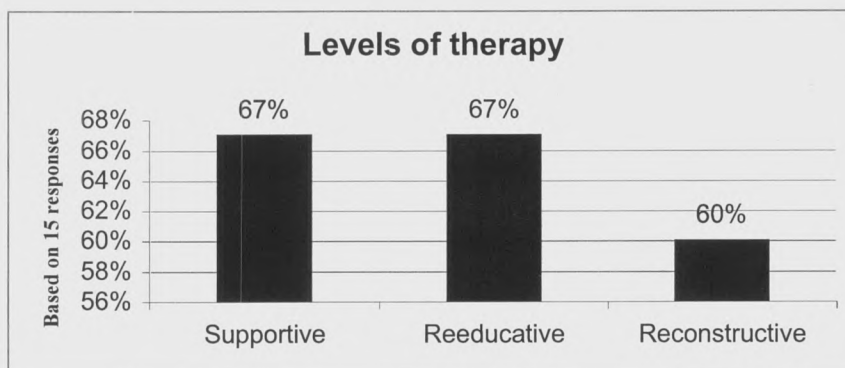


Figure 9. Levels of therapy that music therapy provided to clients with eating disorders.

Interestingly, the frequencies of treatment between the levels were almost equally distributed. The supportive level was used by 66.7% of respondents, the reeducative level 66.7%, and the reconstructive level, by 60% of respondents.

Music Therapy Interventions

Participants were asked to indicate the music therapy interventions that had used in treatment, and to specify the level and context of therapy, i.e group or individual.

Participants completed this form for songwriting, lyric analysis, improvisation, music and imagery, and singalongs. According to music therapists participating in the survey, the most common context of use for all the interventions at all levels was the group context.

The reeducative stage emerged as the most frequently utilized level of therapy, with Lyric analysis and Songwriting representing the most frequently used interventions at this level. When the interventions were compared between levels of therapy, lyric analysis was the most frequently utilized intervention at both the Supportive and Reeducative level of therapy, while Improvisation was the most frequently utilized intervention at the

Reconstructive level of therapy.

Figure 10. summarizes the results.

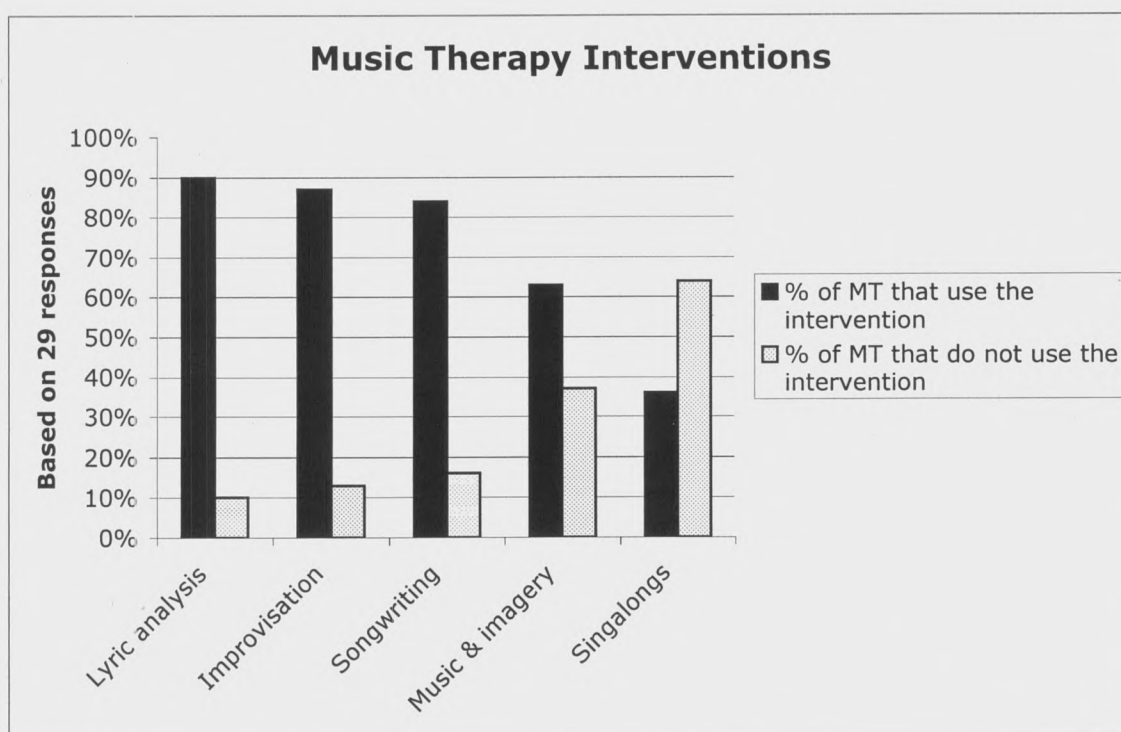


Figure 10. Music therapy interventions

However, when music therapists were asked to share which techniques they felt were most effective in reaching their population, Improvisation with verbal discussion emerged as the most effective intervention. Figure 11. summarizes the results.

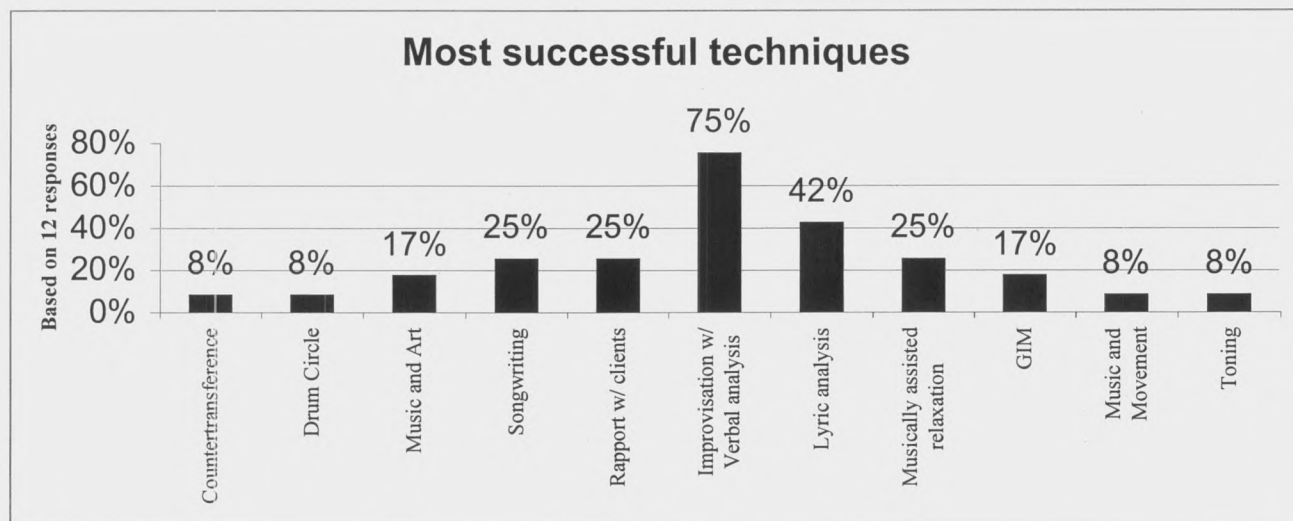


Figure 11. Most successful techniques according to music therapists working with clients with eating disorders

Clinical Improvisation

Participants were asked a series of open-ended questions regarding the use of music therapy improvisation with patients with eating disorders. First, participants were asked to describe how they structured and accompanied the improvisations, and to describe their clients' responses to being asked to musically improvise.

In the next area, participants were asked to describe the musical behavior of their clients including: any observable musical manifestations of pathology, any differences in the musical behavior of client of different diagnoses, and interpersonal dynamics.

The common theme throughout the responses was that clients' responses could be represented on a continuum between diametrically opposing extremes. Participants noted that their clients' responses to music therapy ranged on a continuum that correlated with their degree of pathology or functioning level, as well as their "openness" or "resistance" to treatment. As one participant remarked, "The more advanced the disease, the more

pronounced the resistance.” Throughout the responses, resistance was indeed a central theme and its relation to the musical improvisation and the etiology of the eating disorder is expanded upon in the analysis of the research.

Improvisation: structure and accompaniment.

Participants that used improvisation in their work were asked to share how they structured and accompanied the musical improvisation. All 11 respondents reflected that the level of structure and the style of musical accompaniment were determined by the group’s needs for musical support and their functioning level. The functioning level of the client was specified by the participants as the degree of pathology, the client’s capacity for insight, and maturity level.

In order to facilitate their group’s musical expression, the responses of music therapists participating in the survey indicated that they used a higher level of structure for the improvisation and in their accompaniment for lower functioning patients, and less structure for higher functioning patients. One participant noted that she needed to use a higher level of structure for patients that were “new to the group” in order to create a “safe environment” for participation, while another participant described the structure of the improvisation as “pretty loose, I have high functioning (clients.)” The answers of participants revealed that they attempted to maintain a balance between directiveness and openness in their instrumental accompaniment. The responses of participants revealed that they provided just enough structure to facilitate the musical expression but little enough to allow the clients to assume responsibility for their music.

For example, one participant wrote that she played, “as little as possible (but still providing structure/holding of the musical space).” Another participant described how

most of her improvisations were “very structured, but not so that the clients become defensive because the task is too childish,” while another participant stated, “If there is an inherent leader in the group, I minimize my role in the improvisation.”

Participants also indicated that they attempted to minimize their role in the improvisation in order to allow for the patients to develop their own musical presence and to gain insight into their emotions. One participant wrote that her accompaniment would, “Depend on what the group needs...sometimes its good to be a strong musical presence, other times it is more beneficial for clients to be the prevalent musical presence.”

However, the answers of participants revealed that there was a delicate balance in the group’s needs in the music at any one time, as one participant described how her accompaniment was determined by the “observation of the client’s need during music-making: reflection or distraction, leader/follower, parallel, etc...”

Several participants mentioned that they mainly used drumming and percussion in order to achieve this balance. One participant noted that she predominantly used the drum circle style of improvisation and would play part of the drum circle yet would “provide a grounding beat if necessary.” Another participant mentioned that he used only rhythm instruments so that group members could experience success even without having prior musical experience.

Clients’ reactions to improvisation.

Participants were asked to describe the reactions of clients with eating disorders to being asked to musically improvise. Upon analysis, their responses revealed that clients’ reactions could best be represented on a continuum with “Open and willing to

participate” on one end of the spectrum to “resistant, and unwilling to participate” on the other.

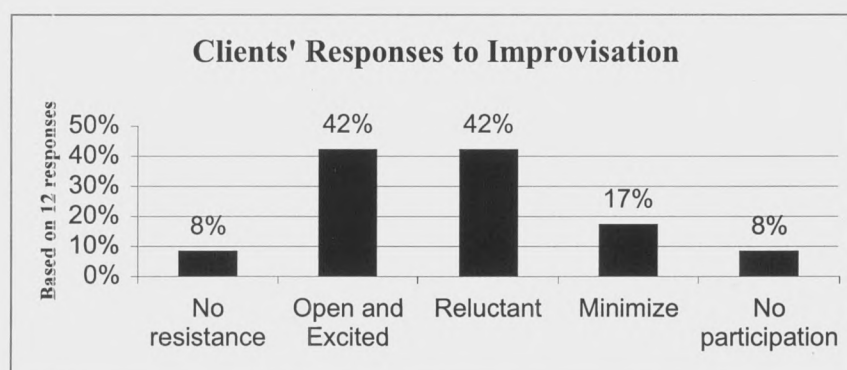


Figure 12. Reactions from clients with eating disorders to musical improvisation

Two of the most commonly described reactions mentioned by five out of 12, or 42% of the participants, were those of initial hesitation and reluctance or, conversely, excitement and enthusiasm. One participant wrote, “Some were open and excited, while others appeared fearful and reluctant. Many times, their reaction was dependent on their openness to receive treatment.” Two participants mentioned ways that patients would “minimize” the activity, either by “rolling their eyes,” or making fun of the group behind her back. Three participants reported that they did not encounter any resistance.

Musical manifestations of pathology.

Participants were asked to describe any manifestations of pathology in the music of clients with eating disorders. Their responses reflected a range from ‘no pathology’ to ‘dissociation’. The majority of participants, however, (6 out of 9, or 67%) described musical manifestations of pathology in terms of a “restricted range” of musical and emotional expression. This “restricted” music was described in a number of ways

including a limited use of dynamics, little differences in playing music of different emotions, and simple and unchanging rhythms. Participants described the music of clients as either very soft or very loud and repetitious.

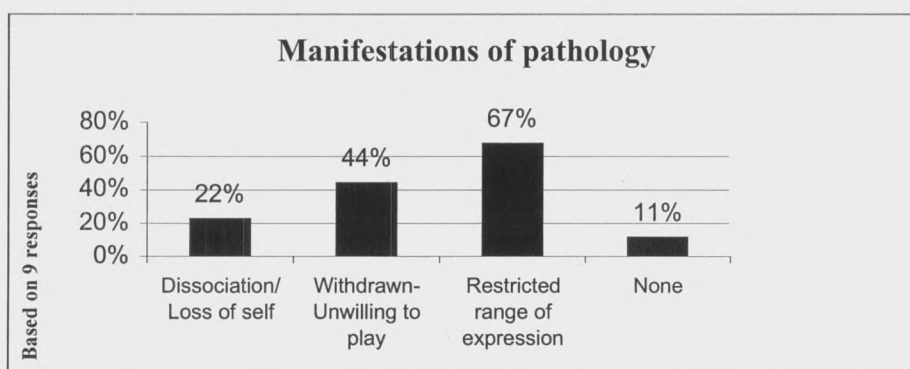


Figure 13. Musical manifestations of pathology

Four participants, or 45%, defined musical manifestations of pathology as “nonparticipation” or resistance to the activity. Two participants (30%) described “dissociative” behavior of patients as music that was rhythmically unstable and musically disconnected to other group members. One participant indicated that dissociation was indicated by the client’s inability to make connections and to identify feelings, and one participant described how one patient expressed that she felt she was “somewhere else” during the verbal processing.

Musical behavior between eating disorder diagnoses.

Participants were asked to describe the musical interaction of clients with various eating disorders in a group, and to describe any differences in the musical behavior between patients with different diagnoses. A little over half, or 54%, of participants acknowledged that they did see differences in musical behavior between patients with

different diagnoses. However, when asked to specify these differences, the answers of participants suggested that these differences could best be interpreted in terms of a range of musical behaviors that reflect the patient's level of psychopathology and openness to receive treatment more so than due to characteristic differences based on diagnosis. In fact, the majority of participants described more similar manifestations of pathology among the two groups than between them. For example, participants mentioned that individuals with both diagnoses tended to isolate from each other, i.e. not join each others rhythms and that their musical patterns were often compulsive and repeating.

One participant noted, "Clients with bulimorexia were more resistant to anything but supportive level of therapy. The more advanced the disease, the more pronounced the resistance to the musical participation."

Four out of five participants, or 80% that elaborated on the question stated that the major differences between the musical behavior of Anorexic and Bulimics was that individuals with Anorexia were more "restrictive" and rigid towards change in their playing, while those with bulimia presented as more "outgoing" and "challenging," and "gregarious."

However, despite the consistency of the more "outgoing" bulimic tendencies to the more "restrictive" playing of the anorexic, both subtypes did exhibit signs of rhythmic instability and isolated from others musically. One participant wrote:

"those with bulimia sometimes were not aware of the effect of their playing upon the music of the group; all clients seemed generally concerned about mistakes and therefore the group improvisations would focus on simple and rhythmic groupings as phrases. Limited dynamics, unless insights emerged, then sudden dynamic changes of rageful proportions. Most often these were ultimately a breakthrough from the person. Dissociative qualities emerged as sounding 'out of touch,' the musical ideas didn't fit in well with the group."

Another participant described a similar dynamic, “Those with bulimia tend to be more easily motivated towards full expression, but vacillate in their emotive and rhythmic playing.” One participant described that differences in the musical behavior were “Hard to say based on diagnosis...as with any mixed diagnosis group, there is the same jealousy of the BN pts of the AN patients (I want to be that skinny), and the AN patient’s fear of the BN patients (I never want to be that out of control) some of these issues come up musically.”

One participant stated that that patients with “(Bulimia Nervosa) BN clients tend to be louder and to exhibit more “all over the place behavior, but this is also sometimes in conjunction with a Bipolar diagnosis, or borderline personality...However, I feel the borderline anorexic may also show that tendency if there are bulimic features.”

Dynamics of Music Therapy with Patients with Eating disorders

According to the participants, patients with eating disorders tended to exhibit very polarized styles of interpersonal relating, styles of relating that alternated between ‘enmeshment,’ or conversely, ‘disengagement’ with others. These reactions were exhibited in the group dynamics of music making as well as in the clients’ reactions to the music therapist and are discussed in the following sections.

Group Dynamics

The responses of participants also indicated that the group dynamic reflected a lack of balance in interpersonal boundaries and represented issues with autonomy. Participants described how the group musical dynamic would often alternate between musical isolation to enmeshment with each other. In fact, the majority of participants, 7

out of 10, or 70%, described the common group dynamic as that of “Co-dependency” and “Caretaking.”

One participant describes how this dynamic was characteristic of patients with eating disorders because they tended to be “very agreeable to the suggestions of other, and do not assert themselves.” Another participant discusses that, “Usually there is one or two ‘leaders’ in the group who set the pace for the others...the other group members may support this and join in or may resist and attempt not to conform. There is almost always a lack of attempt to encourage those more bashful, quiet group members to become more expressive.”

While participants acknowledged that sibling rivalry and competition was also exhibited by participants, the predominant dynamic was described as the “sibling cohort” effect, which one participant described as “helping each other stay sick/ill.”

Client/Therapist Dynamics

Music therapists were asked to describe the emotional dynamics in their work with clients with eating disorders. The majority of participants, 10 out of 11, or 91%, described their patients’ reactions in terms of diametric extremes, or split between “very positive/very negative” transferences. One participant described the reactions of patients to her as that of “love or hate,” and their projection onto her as that of a “good mother or a withholding mother.” Several participants also qualified these reactions based on whether these reactions changed after music therapy.

While four out of these eight participants, or 50%, noted that their clients reactions towards them modulated to a more positive manner following the musical intervention, one participant described a completely different scenario in which several

patients appeared to be “kind/amiable – then I hear them making fun of the music group with peers on the unit.”

Two participants noted that the reactions of patients were “very positive overall; rapport is built easily with these patients” and “usually comfortable, trusting.” Another participant described that the reaction of patients towards her was polarized in terms of attachment strategies, stating that clients had “very intense or very aloof” ways of relating towards her.

Countertransference.

The majority of participants reported experiencing feelings of “frustration” and “responsibility/caregiving” towards clients with eating disorders. Specifically, six out of 12, or 50% of participants reported experiencing feelings of “frustration,” while 5 out of 12, or 42%, of participants indicated that their caretaking response was evoked. One participant’s response indicates the intensity of her countertransference in the following statement, “my reaction usually requires more self-exploration than the ones I notice with other populations.”

Another participant succinctly describes her feelings of frustration in the following,

“After 3 months of only Sat. groups, it was frustrating as clients were in treatment for 90 days. The same group of “critical” clients seemed to have “spread the word of their discontent with the group and resistance was high. The interventions that required effort on their part were discontinued and music listening became the group’s focus. As a result, I did not feel that music was the medium of best expression for these clients.”

Participants also reported experiencing emotional reactions related to feelings of frustration including, “anger,” “irritation,” “defensiveness,” and “rejection.”

These feelings of frustration and wanting to care for the patients appeared to be mediated by feelings of helplessness. One participant reported feeling, "helpless at not being able to extend treatment time."

Participants also described several other emotions related to the "Caretaking" reaction including feelings of "concern," "empathy," "sympathy," and "enthusiasm to assist." One participant stated, "I had a feeling of responsibility to ease their pain and contain their feelings. I have a history of an eating disorder and wanted to help them and let them know that they could live without the eating disorder."

Musical countertransference.

Participants were also asked to describe how these emotional reactions may be implicated in their music. Only one out of eight participants, 16%, described how she used the music to reflect their countertransference, and she writes the following,

"I try to use my emotions in my work with clients -- I understand that quite often my response is typical of what the patients elicit from people... so I try to use that in the musical process. Its (sic) often a balance between control, letting go, listening, initiating change, encouragement, expression... Many layers are happening musically. I may not have the answers for them, but I can offer my experience & understanding as a tool for them -- modeling healthy anger, modeling healthy confrontation, etc."

Two participants described how their caretaking reaction was illustrated by their need to create expressive music. One participant stated that she made, "use of various timbres (not just piano, but recorder, xylophone, cello, violin; use of tempo and dynamics contrasts (high energy, slow easy energy, etc); long improvised melodic lines usually in major modes with many modulations."

Another participant stated, "I use the drum circles and improvisations to release my frustrations, anger, and sense of being stuck. I have an excuse to be a bit more wild when I can say that I am merely attempting to free up the clients."

Another three of the eight participants (38%) explicitly describe these countertransferential reactions of wanting to take care of the patients. One participant described that how she “didn’t have time to get bogged down with her own stuff with the client, I work hard to keep it separate so that I can be there for them.” Another participant shared that “I found myself wishing to help foster a warm, family - like group environment via the opening musical experiences. This may have brought up trust issues for some of the women, since I am a male.”

DISCUSSION, IMPLICATIONS, AND CONCLUSIONS

Music therapists working with clients with eating disorders face a challenging task. They frequently encounter very challenging scenarios in their work with clients, including powerful interpersonal dynamics and a population whose response to treatment is often resistant and unsuccessful.

In order to provide the greatest standard of practice to patients with eating disorders, it is important to establish a greater understanding of music therapy processes and dynamics at work with this population. Because this study was an exploratory investigation of the nature of music therapy provision to clients with eating disorders, the focus of the research is descriptive rather than analytical. Throughout the analysis of survey data, several areas have emerged that warrant further exploration.

Discussion of Findings

Although 36 music therapists participated in the survey, only four, or 8%, stated that they worked primarily with patients with eating disorders. Since the researcher used a sample of convenience derived from the national listing, it is possible that music therapists who are not registered members of the national registry are working with clients with eating disorder and were excluded from the sampling frame. Due to this factor, the results of this survey may not be representative of the practice of music therapists that do specialize in eating disorder rehabilitation.

In addition, the reader should be aware that the information in this study is based on data from clinicians that primarily provide music therapy services to patients with diagnoses other than eating disorders. In addition, out of the 36 music therapists participating in the survey, only 18 stated that they were currently working with patients

with eating disorders while 18 based their answers on work done in the past. In addition, several of the open ended questions regarding therapy implementation were answered by only a third of respondents.

Demographic Information

According to the results of the survey, the majority of clinicians treated patients with eating disorders in the inpatient treatment facility wherein music therapy was provided as part of the milieu therapy program. Frequency statistics revealed that the psychodynamic framework emerged as the most utilized paradigm by music therapists working with patients with eating disorders, followed by the eclectic, humanistic, and cognitive theoretical paradigms. However, if both cognitive and cognitive-behavioral paradigms were combined into one category, they would exist as the most frequently utilized paradigm.

Therapy Implementation

According to participants, the primary goals of music therapy with patients with eating disorders were to increase cognitive functioning and emotional expression. Most clinicians also indicated that they derived their ongoing assessment of the client based on the client's functioning in these areas. Respondents indicated that they predominantly worked on the supportive and reeducative levels of therapy.

Music Therapy Interventions

The use of improvisation with verbal processing emerged as the most successful therapeutic intervention in the treatment of patients with eating disorders. However, when interventions were compared in terms of frequency of use, lyric analysis emerged as the most frequently utilized intervention by music therapists. This finding reflects the fact

that although improvisation did emerge as the most frequently utilized intervention at the reconstructive level of therapy, the majority of clinicians that work with clients with eating disorder provide do so in the supportive and reeducative levels.

The least frequently utilized intervention was the singalong, used by only 36% of participants. In addition, all of music therapy interventions including improvisation, lyric analysis, and songwriting, music and imagery, and singalongs were used most often in the group context.

Clinical Improvisation

Structure and accompaniment.

The responses of music therapists working with the eating disordered population illustrated that their accompaniment for the improvisation was determined by the groups' needs for structure and their capacity to maintain this musical structure on their own. The music therapists participating in this survey described how they attempted to provide just enough structure of the improvisation to allow for the clients to assume responsibility for the music. This finding parallels what Bruch (1988) writes, in that "the complex task of therapy involves guiding the client in her search for identity through the discovery of natural impulses and repressed emotions."

Musical behaviors of clients with eating disorders.

According to participants, the music of clients with eating disorders was often "polarized" in nature, for example, either very loud or very soft, or 'lacking in control' versus 'very restricted'. Music therapists reported that the balance of the musical expression in terms of tempo and dynamics, as well as the client's level of rhythmic

organization, could be represented on a spectrum that indicative of the client's degree of pathology or well-being.

Interpersonal Dynamics

Group Dynamics

The musical interactions of patients with eating disorders in the group context indicated their rigid and polarized interpersonal styles. According to the participants, clients with eating disorders tended to employ two particular styles of interaction, the first of which is characterized by the emotional withdrawal and musical isolation by patients with eating disorders towards others. The second interpersonal style is characterized by caretaking/supportive behaviors and approval-eliciting behaviors.

Isolation.

Both participants and the review of the literature indicate that clients with eating disorders often "isolated" from musical contact with others.

Loth (2002) describes how the clients' difficulty in musically connecting to others reflects their issues with intimacy, "a common theme was how to maintain your identity whilst being in contact with others...it is as if each person's sense of self is so fragile that by allowing it to mingle with others in the form of sounds, to adapt a little and change in order to form something shared, she will lose it all together. She will be obliterated, subsumed, or merged. This illuminates something of the anorexic/bulimic experience (p. 102)."

The musical isolation from others and the lack of emotional expression may indicate the client's need to avoid difficult emotions aroused from contact with others. If the client avoids contact with others, she may avoid experiencing uncomfortable

reactions from others, including rejection. Perhaps patients with eating disorders are also afraid that if they let others in to share their experience, they will lose some of their "specialness." Isolative behaviors including the solitary act of dieting and restriction may provide the source of self-esteem for these patients, and therefore represents their superiority to others. However, because this inflexible interpersonal style is based on being "special," it prevents the client from understanding and experiencing their true feelings.

Caretaking.

It is interesting that when participants were asked to describe the musical interaction of patients with eating disorders in the group, the common response by participants was that clients had a hard time musically connecting to others. However, when participants were asked to describe the group dynamic, the most common response was that clients with eating disorders sought to care for and support the music of others in the group. However, the music therapists participating in this study interpreted this "caregiving" as the cohort effect; one participant responded that patients, "helped each other stay sick."

This polarized interpersonal style may indicate the nature of the client's conflict. Both the literature review and the results of the study suggest that the client's tendency to care for the needs of others indicates a maladaptive coping strategy in which her self-esteem is based on her ability to be sensitive to the needs of others. For the client with an eating disorder, being supportive and taking care of others enables her to feel virtuous and superior, and therefore provides the client with a false sense of self-esteem.

These inflexible interpersonal styles are maladaptive because they prevent the client from integrating and understanding their authentic feelings. Most of the music therapists participating in the survey stated that the goal of music therapy was to help the client increase her awareness of the eating disorder and maladaptive thought processes. It is possible that music therapy may also be used to help clients become aware of how these rigid interpersonal styles are also being used as a defensive mechanism. Even if clients with eating disorders maintain healthy weights and eating practices, it may still be maladaptive for them to base their self-esteem on either subservient and altruistic behavior or isolation from others.

Therapist/Client Dynamics

Music therapists participating in the survey also reported that patients with eating disorders tended to respond to them in a polarized manner, either very engaged or very indifferent and disengaged. The majority of participants described the reactions of patients to them as either “very positive/very negative.”

One participant describes a scenario in which several patients appeared to be “kind/amiable – then I hear them making fun of the music group with peers on the unit.” This example may illustrate the complexity of providing therapy to patients with eating disorders as well as the difficulty in assessing patients based on overt musical participation. In addition to primary or explicit resistance to the activity, patients may covertly “resist” the activity.

The fact that the most common reactions to the patients were those of “frustration” and “caregiving/caretaking” also corresponds to what has been published in the literature. In fact, Zerbe (1997) describes how countertransferential dynamics ranged

from “care-taking” desires to want to hold the patient as well as the frustrating experience of being seen as the controlling mother or the person who is trying to take control of the patient’s body.

Loth (2002) mentions a similar dynamic in her group work with patients with eating disorders. She describes the emotional impact of her patients’ resistance to the improvisation stating that she felt, “rejected and humiliated,” and also “deskilled and useless” (p.103).

These countertransferential reactions may illustrate the client’s underlying feelings of inadequacy that have been projected onto the therapist. However, these projective identifications may also provide a means by which clinicians may better understand the emotional content of the patient’s issues. However, only one participant stated she used her countertransference to reflect back to the patients the impact their emotions had onto her. Most participants described how their countertransferential feelings of “caregiving” and frustration were acted out in the music.

Two participants said that their reaction enticed them to provide musical variation by using a variety of instruments and contrasting tempos and dynamics. One participant remarked that, “I use the drum circles and improvisations to release my frustrations, anger, and sense of being stuck. I have an excuse to be a bit more wild when I can say that I am merely attempting to free up the clients.”

These illustrations of countertransference in the music may indicate that certain interpersonal dynamics are being reenacted. It could be that the client’s lack of expressiveness in the music is “frustrating” to the music therapist who may then attempt to “nourish” the sound with expressive musical qualities. However this tendency may

reinforce a maladaptive scenario that deprives clients of expressing their emotions and discovering their authentic voice.

Limitations of the Study

Due to the small sample size and convenient measures to derive selection, the study's generalizability is limited. Also, because the researcher was the primary person gathering and analyzing data, some researcher bias may exist. Further, because participants were permitted to skip questions, participant attrition weakened the validity of the results. Although 36 participants met the criteria for inclusion in the study, several questions were only answered by a third of the research sample. Therefore, the initial questions concerning treatment setting, theoretical orientation, and patient demographics may not accurately represent the participants who answered the open-ended questions regarding therapy implementation.

Although the use of the survey software allowed the researcher to provide anonymity for the participants, it disallowed continuity between the answers of participants. This limitation reduced the ability of the researcher to discover individual trends in the data across various categories.

Implications for Music Therapists

The eating disordered individual is driven to constant activity in order to avoid difficult emotions (Goodsitt, 1997). While verbal therapies use language and thinking in anticipation of action and provide an indirect intervention, experiential therapies such as music therapy are action and process oriented (Bruscia, 1998). The use of music as emotional communication may be a viable use in treatment for individuals with eating disorders who customarily use the body as a symbol of emotional distress and have the

tendency to intellectualize emotions. Through the interactive process of music, the client can work through arrested stages of development, explore feelings and gain a new awareness of self, and develop insight into the cognitive distortions through the use of symbol and metaphor.

However, many patients who enter treatment for an eating disorder may display a high level of resistance to therapy because the eating disorder represented their coping mechanism, self-esteem, and essentially, their identity. For many clients, the eating disorder may have developed as a defense to help them guard against overwhelming and painful emotions resulting from abuse or issues during early development. Clients whose issues are due to past trauma have therefore encoded these experiences in a procedural or bodily manner; as a result, they may be extremely resistant to participating in active musical experiences in which these painful emotions can be evoked.

Therefore, it may be helpful to begin with structured musical activities in which the client can participate with a great deal of success. Successful participation in these structured musical experiences may help to reduce the resistance and empower the client to explore the deeper issues. While lyric analysis can be used to help patients to develop an awareness of the disorder, more active musical experiences such as improvisation, may be a good means to engage the client's individuality and to help patients integrate deeper levels of emotional experience.

Music therapy improvisation possesses the unique ability to function as both a diagnostic and therapeutic tool. As a diagnostic tool, the client's musical behaviors may communicate levels of functioning and indicate the nature of the internal conflict. Stephens (1983) writes "In the act of playing we release physical energy. We may

express a specific emotion or emotions at any moment in our playing; our playing reflects who we are, how we organize ourselves, and how we feel as we move through time...In improvising with others we are also dealing in a fundamental way with our relatedness to other people" (p. 30). Therefore, the information derived from musical improvisation can be used to help the client identify and understand her own emotions in the here and now.

Goodsitt (1997) writes that the therapeutic task is to encourage the patient to "Let go and take a chance on life," and to engage the client's individuality, "Therapy is an endeavor that gives the patient an opportunity to occupy more psychological space" (p. 208). The concept of musical space has particular significance when viewed in this manner. Without words, the therapist can create a musical and interpersonal space where the clients can begin to explore their inner worlds.

Music therapists participating in the survey reported that they provided the minimum level of structure necessary to facilitate the improvisation. Despite the resistance of many clients to musical improvisation, clinicians attempted to achieve a balance between meeting the clients' structural needs for improvisation and challenging them to take over more responsibility for the music. However, many clinicians also reported that they often experienced feelings of frustration and helplessness that challenged their ability to provide this balance in the improvisation. While these countertransference reactions may provide the therapist with insight into how the client is feeling, they may be difficult to musically "contain" as well as emotionally endure.

Although the music of clients with eating disorders may be very emotionally restrictive, the therapist should not 'force-feed' the emotional content into the musical expression, but instead, remain open to detecting any subtle change in the music in order

to facilitate and expand this expression. As the goal of therapy is to help the client get in touch with her own impulses and emotions, the client should maintain responsibility for the emotional expression.

Finally, several of the music therapists who participated in the survey described how easily rapport was built with clients. As human beings, we all enjoy being admired and adored, and it may be tempting to believe this veneration. However, this dynamic may also reflect the characteristic preoccupation that individuals with eating disorders have with pleasing others. Therefore, a possible pitfall may be to interpret a client's pleasing, attentive behavior or openness to participation levels as healthy, 'good,' or adaptive, and resistance or lack of participation as 'bad', or maladaptive. This tendency may reinforce a destructive cycle of thinking and reinforce what Hilde Bruch referred to as "systematic training in dishonesty."

Due to these intense transference dynamics, music therapists working with clients with eating disorders may find it helpful to process these reactions in supervision. A peer supervision group with other clinicians or music therapist who work with eating disorders may provide an invaluable means of support for the clinician and provide a forum where the therapist can explore and process these issues.

Conclusion

Although the use of improvisation was cited as the most successful therapeutic intervention to use with clients with eating disorders, it is not the most frequently utilized intervention according to clinicians taking part in the survey. This result appears to stem from multiple factors, not the least of which is the client population's complex and deeply rooted resistance to treatment. However, other issues, including the context of the provision of care, may also have played a part in this outcome.

Most of the music therapists participating in this survey did not specialize in eating disorder rehabilitation and provided music therapy to clients with other mental health issues. In contrast to the published literature, the majority of music therapists providing services to patients with eating disorders did so in the group context. Furthermore, the majority of these clinicians treated clients in inpatient psychiatric facilities where they tended to provide treatment on the supportive and reeducative levels of therapy, more so than on the reconstructive level of therapy. In addition, although participants indicated that they used a variety of interventions with the client population, the use of lyric analysis was slightly higher than the use of other interventions, especially in these initial stages of treatment. However, several music therapists participating in this survey did indicate that they worked on the reconstructive stage of therapy, in which case, clinical improvisation emerged as the predominant therapeutic intervention.

These clinicians were asked to elaborate on their use of improvisation with the client population. The results of this part of the survey confirmed much of what has been published in the literature concerning music therapy in the treatment of eating disorders, especially with regard to client musical behaviors and interpersonal dynamics.

The musical behaviors of clients with eating disorders appeared to indicate the range of their pathology in three primary ways including: the restricted range of emotional expression, difficulty in musical interaction with other group members, and rhythmic instability. Many clinicians described how group members not only had difficulty maintaining a stable pulse, but experienced considerable difficulty rhythmically connecting to one other. Other signs of pathology concerned the restricted emotional range of the musical expression, which was indicated by the clients' limited use of dynamics and very simple and unchanging rhythmic phrases.

Music therapists participating in the survey also reported that they attempted to achieve a balance between providing enough structure to facilitate the improvisation, and challenging them to take over more of the responsibility for the music. However, providing this balance was also affected by the powerful interpersonal dynamics at play. Clinicians reported that they often experienced feelings of frustration and helplessness, reaction that challenged their ability to provide this musical space for the clients. Participants described how they attempted to make up for the lack of variation in the patient's music by playing very expressively and that often, the lack of client participation and resistance made it difficult to facilitate the improvisation.

In conclusion, while the majority of the music therapy literature has focused on the use of improvisation as a therapeutic intervention with the eating disordered population, music therapists participating in this survey indicated that they used a variety of interventions designed to enhance client participation, and that the specific use of interventions throughout the therapeutic process depended on their clients needs and abilities in treatment.

Suggestions for Future Research

This survey represents a first step in the development of a body of research with this population. However, several problems associated with the use of a questionnaire also affected the outcome of this research. These problems, especially participant attrition and the construct validity of several questions, further weakened the external validity of results. Participants noted that the mutually exclusive categorization of therapy interventions by levels, goals, and eating disorder diagnosis forced them to analyze their experience using a behavioral framework terms and thus reduced the essence of the experience. One participant noted that isolating music therapy approaches by intervention and goals "was overly reductionist and naive in comparison with how clients use these approaches for their own goals."

Another factor that affected the both the external and internal validity of the research concerned the convenient measures used in sampling the population. Although the sample was derived from the national listing of registered music therapists, it could be that many therapists that work with the eating disorder patient population are not listed in the national registry. Perhaps a more representative sample could be ascertained by contacting inpatient treatment facilities specializing in the treatment of eating disorders and inquiring whether or not they have music therapy. Although this sample may provide more detailed information regarding the use of music therapy with the patient population, a possible trade off may be the small number of participants.

In order to better understand the nature of music therapy with eating disorders, qualitative research methods including the case study and the focus group designs could be used. These case studies could include not only individuals but small groups of

individuals interviewed by phone or in person and this may increase levels of participation. The use of the focus group may also be an appropriate methodology to gain a better understanding of how music therapists that work with eating disorders view their own work.

In addition, future research should seek to control for possible confounding variables including: the severity of the disorder, age, and maturity level of the clients. Participants taking part in the survey mentioned that they often took the client's age and maturity level into account when implementing music therapy interventions as these variables also influenced the client's capacity for insight.

Several of the music therapists taking part in the survey used musical behavior as a means of assessment. Future research could address the notion of progress and health in the music of patients with eating disorders. In fact, several of the participants mentioned that they would have like to have been asked how patients with eating disorders manifest their health in the music.

In addition, because the treatment of patients with eating disorders is often described as unsuccessful and protracted, it would be interesting to ask participants whether they feel that music therapy has been an effective modality for reaching the population. While several participants did felt that it was an effective modality for patients with eating disorders, others shared their opinion that due to the high level of resistance and consequent lack of participation, it was unsuccessful. Future research could seek to address which clients with eating disorders are the best candidates for music therapy.

Lastly, future research could address the experience of clients who had received music therapy during their treatment, and case study interviews could be conducted in order to determine what interventions and aspects of the music therapy process they found most useful in their treatment.

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Appendix A



Music therapy in the Treatment of Eating Disorders

Dear Colleague,

I am a Master's student at Montclair State University in Upper Montclair, NJ. For my thesis, I wish to inquire about the nature of the music therapy services rendered to patients with eating disorders. The following questionnaire is designed to compile information regarding the use of music therapy strategies and therapy implementation in the treatment of clients with eating disorders. As the use of creative arts therapies with clients with eating disorders continues to rise, it is imperative to establish knowledge concerning the context of the provision of care as well as information regarding the experience of working with clients with eating disorders.

You are being asked to complete and to mail back the following questionnaire that seeks to investigate music therapy work with clients with eating disorders. This survey will be limited to those music therapists listed in the American Music Therapy Association's annual sourcebook as working with eating disorders.

Your participation in completing this survey is greatly appreciated. By completing this survey, you will be participating in the first systematic investigation of the use of music therapy in eating disorder rehabilitation. The results of this survey will provide clinicians with current information of the practice of music therapy with clients with eating disorders and the most effective strategies according to practicing clinicians. Participants are also asked to share their personal experience of working with clients with eating disorders. This information may prove invaluable to clinicians new to working with such a complex treatment population and will also educate other members of the treatment team about music therapy.

Your participation in this survey is voluntary. Should you elect to return the completed survey, your response will serve as your consent to participate in the survey. Please read the following consent form, but in order to ensure your anonymity, please do not sign it or return it.

In addition, please complete the questionnaire only if you have in the past or are currently working with clients with eating disorders. If you do not or have not worked with clients with eating disorders, please fill in the box with the option stating 'I do not work with clients with eating disorders' and mail back the uncompleted questionnaire.

Thank you,

Marah E. Bobilin, MT-BC

Appendix B



**MONTCLAIR
STATE
UNIVERSITY**



School of the Arts
Department of Music
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CONSENT FORM FOR ADULTS

The purpose of this consent form is to provide you with information you need in order to decide whether you want to participate in a research project. Please read the information below carefully. You are encouraged to ask questions before deciding whether to participate in the study and to ask questions at any time during the course of the study.

Project Title: Music therapy in the Treatment of Eating Disorders

Purpose: The purpose of this study is to describe the use of music therapy in eating disorder rehabilitation including the process of providing music therapy to clients with eating disorders as well as a description of the transference dynamics.

Procedures: As a participant in this study, you will be asked to answer 19 questions in multiple choice and short essay format regarding music therapy implementation, treatment protocol, and the process of music therapy work with clients with eating disorders. These questions concern patient demographics, your music therapy assessment process and interventions, and the therapist/client dynamics.

Time involvement: Your participation in this research project will take approximately twenty-five minutes to complete.

Risks: The risks associated with participating in this study are no greater than those encountered in everyday life.

Benefits: Other clinicians working with clients with eating disorders will gain insight into the nature of music therapy work with this complex client population. Clinicians may also benefit from the knowledge of effective and ineffective music therapy interventions and common countertransference reactions experienced by music therapists working with this client population.

Confidentiality: Your individual privacy will be maintained and your identity will not be revealed in any written documents and oral presentations resulting from this study.

Voluntary participation: Your participation in this study is voluntary. You have the right to decline to participate, to withdraw your consent, or to discontinue participation at any time without penalty. You have the right to refuse to answer particular questions. Please do not sign and return this consent form. By returning the questionnaire, your consent is "oral".

For questions about the study: Contact Marah E. Bobilin, MT-BC (marabobilin@yahoo.com, 256-694-4302)
Music Therapy Department
C/O Marah Bobilin
612 Allerton Ave.
Bronx, NY 10467



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For questions about your rights: If you have any questions about your rights as a research participant, you may contact the IRB chair, Debra Zellner (zellnerd@mail.montclair.edu, 973-655-4327) or the IRB Administrator, Fitzgerald Edwards (edwardsf@mail.montclair.edu, 973-655-7781).

This consent form is yours to keep. A summary of study results will be provided to you upon request.

Marah E. Bobilin, MT-BC
Primary Investigator

Signature

Date

Karen D. Goodman
Faculty Sponsor

Signature

Date

Appendix C

Survey of Music Therapists Working in Eating Disorder Rehabilitation

Background and demographic data

1. Do you currently work with clients with eating disorders?
 - a. Yes
 - b. No
 - c. Not currently, but I have in the past. Please specify dates of work in terms of month/year - month/year _____
 - d. No, but I am interested in working with this population.

*If b or d, please stop here and return questionnaire.

**If a or c, please continue with the questionnaire.

***If you answered c, please answer questions regarding your previous work with clients with eating disorders, although these are stated in the present tense.

2. What setting do you treat patients with eating disorders? Please circle all that apply.
 - a. Private practice
 - b. Inpatient treatment facility, specializing in eating disorders
 - c. Hospital
 - d. Other, please specify: _____
3. In this setting, do you work primarily with patients with eating disorders?
 - Yes _____
 - No _____
 - a. If no, please indicate other populations that receive music therapy.

4. Please give percentages of clients for each diagnostic classification that your work with per treatment context.

- a. **Individual clients**

Anorexia: _____

Bulimia: _____

Eating disorder, NOS: _____

- b. **Groups**

c. Anorexia: _____

Bulimia: _____

Eating disorder, NOS: _____

d. **Other (Support groups, families, etc)**

Anorexia: _____

Bulimia: _____

Eating disorder, NOS: _____

I. Theoretical orientation and approach

5. What is your theoretical orientation?

6. Please describe your treatment philosophy as it relates to working with patients with eating disorders? Please indicate:

a. Your belief concerning the etiology of the disorder.

b. Your belief as to how music therapy should be used with this population.

c. Your belief as to how progress can be measured

d. Your assessment process

II. *Therapy Implementation*

7. How is music therapy rendered to patients with eating disorders?
 - a. Please describe the method of referral.

8. In your work with clients with eating disorders, what level of therapy do you provide? Please circle all that apply and indicate the music therapy interventions as well as treatment context, i.e. individual or group setting and/or type of group.
 - a. Supportive level: interventions that seek to support and maintain rather than to provoke change
 - b. Re-educative level: interventions that seek to help the client identify cognitive distortions (i.e. helping the client to become aware of the ways in which the eating disorder is controlling her)
 - c. Reconstructive level: interventions that assist the patient in integrating aspects of the self; a process approach to therapy in which the therapist and client explore maladaptive relational patterns and emotional reactions in order to help the patient resolve these issues within the therapeutic alliance.

9. For each level of therapy in which you work, please circle the specific interventions that you use.

In addition, please indicate if this is used in the group or individual setting.

- a. Supportive level
 - i. Songwriting
 - Group
 - Individual setting
 - ii. Lyric analysis
 - Group
 - Individual setting
 - iii. Improvisation
 - Groups
 - Individual setting
 - iv. Singalongs

- Groups
- Individual setting

v. Music and imagery

- Groups
- Individual setting

vi. Other, please describe:

- Groups
- Individual setting

b. Re-educative level

i. Songwriting

- Group
- Individual setting

ii. Lyric analysis

- Group
- Individual setting

iii. Improvisation

- Groups
- Individual setting

iv. Sing-alongs

- Groups
- Individual setting

v. Music and imagery

- Groups
- Individual setting

vi. Other, please describe:

- Groups
- Individual setting

c. Reconstructive level

- i. Songwriting
 - Group
 - Individual setting
- ii. Lyric analysis
 - Group
 - Individual setting
- iii. Improvisation
 - Groups
 - Individual setting
- iv. Sing-alongs
 - Groups
 - Individual setting
- v. Music and imagery
 - Groups
 - Individual setting
- vi. Other, please describe:
 - Groups
 - Individual setting

10. Please share any musical repertoire that you have used in your work with patients with eating disorders.

- a. Please list the song titles and composers.
- b. Please describe the context that it is used,(i.e. lyric analysis, sing-along, etc...)

Title

Composer

Context

11. Are their common musical manifestations of pathology in your clients? If so, please describe.

12. Have you noticed any differences in the musical behavior of clients diagnosed with Anorexia Nervosa as opposed to clients diagnosed with Bulimia Nervosa or Eating Disorder, Not otherwise specified?

a. Yes/No

b. If so, please describe:

c. If you work with a group of both bulimic and anorexic patients, how do they interact musically?

13. Please describe how recurrent emotional themes may be implicated musically. For example, if shame or rejection is a recurring theme, how is this illustrated within the musical context?

14. If you work with groups, please describe common group dynamics, i.e. sibling rivalry, attachment independence.

15. If you use improvisation, please describe how you orchestrate this activity.

a. How do you determine the level of structure for these improvisations?

b. How do you determine your musical accompaniment?

c. How do clients react to being asked to improvise musically?

16. What techniques have proved most useful for you in reaching your population?

17. What are some of the issues you face in your work with patients with eating disorders?

- a. Please describe what you consider to be obstacles to your client's progress in treatment.

18. Please describe the ways in which your clients relate to you.

- a. What are some of the emotional reactions that patients have towards you?

19. Please describe any emotional reactions towards your clients during the music therapy session.

- a. If so, how is this emotional experience reflected in your music-making and/or accompaniment?